

REFERRAL FORM FOR BEHAVIORAL EVALUATION

Minnesota Vision Therapy Center
1650 West 82nd Street
Bloomington, MN 55431
Phone: (952) 844-0844 or toll free (877) 756-0844
Fax: (952) 844-0810

Patient Name _____

Date of Exam _____ Date of Birth _____

Parent/Guardian Name(s) _____

Address _____

Phone (H) _____ (W) _____

Preferred Person and phone number for us to call to set up appointment:

Referring doctor or other individual (name, address, phone, fax):

Reason for Referral:

To set up a no-charge referral appointment:

Fax or mail us this completed referral form. If you are sending this from an optometrists' or ophthalmologists' office, please send a copy of your most recent exam (must be within the past year). For anyone else, please let the patient know that an eye exam done within the past year is required. We do have a reference list if the patient needs information on eye care clinics.

Website: www.minnesotavisiontherapy.com